CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1548	**Date: JULY 9, 2008**
	Change Request 5993

Transmittal 1530 sent to you on June 6, 2008, is being corrected and resent because of 2 errors in the manual portion of the instruction. The longstanding payment policy replaces language in Section H. Information in Section F to calculate critical care time and the Table in Section G has been corrected for consistency with coding information in the American Medical Association's Current Procedural Terminology. There are also clarifications in Sections C, E and I which are explained explicitly in this Transmittal's Summary of Changes. All other information in this revision remains the same.

SUBJECT: Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

I. SUMMARY OF CHANGES: This transmittal corrects two errors stated in the initial transmission. The longstanding payment policy replaces language in Section H to correctly say that hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient. Information in Section F to calculate critical care time and the Table in Section G is corrected. It is now consistent with the coding information in the American Medical Association (AMA) Current Procedural Terminology (CPT). Additionally, medical record documentation for each physician is more clearly written in Section I and the requirement for CPT code 99291 is underlined for emphasis. The policy for staff coverage and follow-up visits is more clearly written under CPT code 99292 in Section I. Coding information for critical care to neonatal and pediatric patients in Section A is deleted pending AMA CPT changes. A grammatical clarification is made in Section C for time spent reviewing or discussing patient information which meets full attention. Clarifications are made to Section E components (off the unit/floor and split/shared service) to convey Medicare policies more clearly.

This transmittal represents Medicare payment policy for critical care services and replaces all previous language. It includes the AMA CPT definitions of critical care and critical care services. It incorporates general Medicare evaluation and management payment policies that impact payment for critical care services. It adds a new CPT code for 2008 (36591) which replaces code 36540. Code 36591 identifies a bundled vascular access procedure when performed with a critical care service.

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	12/30.6.12/Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1548	Date: July 9, 2008	Change Request: 5993

Transmittal 1530 sent to you on June 6, 2008, is being corrected and resent because of 2 errors in the manual portion of the instruction. The longstanding payment policy replaces language in Section H. Information in Section F to calculate critical care time and the Table in Section G has been corrected for consistency with coding information in the American Medical Association's Current Procedural Terminology. There are also clarifications in Sections C, E and I which are explained explicitly in this Transmittal's Summary of Changes. All other information in this revision remains the same.

SUBJECT: Critical Care Visits and Neonatal Intensive Care (Codes 99291 – 99292)

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: This transmittal corrects two errors stated in the initial transmission. The longstanding payment policy replaces language in Section H to correctly say that hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient. Information in Section F to calculate critical care time and the Table in Section G is corrected. It is now consistent with the coding information in the American Medical Association (AMA) Current Procedural Terminology (CPT). Additionally, medical record documentation for each physician is more clearly written in Section I and the requirement for CPT code 99291 is underlined for emphasis. The policy for staff coverage and follow-up visits is more clearly written under CPT code 99292 in Section I. Coding information for critical care to neonatal and pediatric patients in Section A is deleted pending AMA CPT changes. A grammatical clarification is made in Section C for time spent reviewing or discussing patient information which meets full attention. Clarifications are made to Section E components (off the unit/floor and split/shared service) to convey Medicare policies more clearly.

The transmittal replaces Chapter 12, §30.6.12. It incorporates Medicare evaluation and management payment policies that impact critical care services. The current language from AMA CPT for definitions of critical care and critical care services is included. A coding change from AMA CPT 2008 is added which is for a vascular access procedure under section J (code 36591), a bundled procedure and deletes CPT code 36540.

B. Policy: This transmittal explains the definition of critical care services and how to correctly bill for these services. Explanations are stated for medically necessary services, full physician attention, counting the hours of critical care billing, performance of other evaluation and management (E/M) services on the same day as critical care services, group practice issues, services by a qualified nonphysician practitioner (NPP), bundled procedures, global surgery issues, ventilation management, and teaching physician issues. Physician time addresses services off the unit/floor, split/shared services, unbundled procedures, inappropriate use of time and family counseling and discussions.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5993.1	Contractor shall instruct physicians and qualified NPPs on the current definitions and interpretations of critical care and critical care services used in Medicare presented in §30.6.12 (A), (B) and AMA CPT.	X			X						
5993.1.1	Contractor shall instruct physicians and qualified NPPs that critical care services must meet medical necessity in accordance with the definitions referenced in BR 5993.1.	X			X						
5993.2	Contractor shall instruct physicians and qualified NPPs on what is meant by the full attention of the physician, and what may be reported and billed for critical care services, as identified in §30.6.12 (C).	X			X						
5993.3	Contractor shall instruct physicians and qualified NPPs that a qualified NPP may perform critical care services within the scope of practice and licensure requirements for the NPP in the State where he/she practices.	X			X						
5993.3.1	As identified in §30.6.12 (D), Contractor shall instruct physicians and qualified NPPs that the qualified NPP shall meet the collaboration and billing requirements and physician supervision requirements in Medicare.	X			X						
5993.3.2	Contractor shall instruct physicians and nonphysician practitioners that a physician assistant shall meet the general physician supervision requirements (§30.6.12 D).	X			X						
5993.4	Contractor shall instruct physicians and qualified NPPs that time spent off the unit or floor (excluding time spent reviewing or discussing patient information which meets full attention as identified in Section C) where the patient is located may not be billed as critical care services as this is considered bundled pre- and post service work (§30.6.12 E.1).	X			X						
5993.5	Contractor shall instruct physicians and qualified NPPs that critical care services shall not be performed or billed as a split/shared E/M service (§30.6.12 E.2).	X			X						
5993.5.1	Contractor shall instruct physicians and qualified NPPs that a critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified NPP and shall not be representative of a combined service between a physician and qualified NPP (§30.6.12 E.2).	X			X						
5993.5.2	When circumstances warrant the Contractor may determine by medical review if critical care services were incorrectly reported as a split/shared service.	X			X						
5993.5.3	Contractor shall deny a claim for critical care service that is a split/shared service with the following messages: Claims Adjustment Reason Code: 150 – Payment adjusted because the payer deems the	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	information submitted does not support this level of service. Remittance Advice Reason Code: N180 – This item or service does not meet the criteria for the category under which it was billed. Medicare Summary Notice: 17.11 – This item or service cannot be paid as billed. For unassigned claims use add-on message 16.34 – You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'you may be billed' column; or For assigned claims use add-on message 16.35 – You do not have to pay this amount.										
5993.5.4	Contractor shall instruct physicians and qualified NPPs that when CPT code time requirements and critical care criteria are met for a medically necessary service by a qualified NPP the service shall be billed using the appropriate individual NPI number (§30.6.12 E.2).	X			X						
5993.6	Contractor shall instruct physicians and qualified NPPs that time involved performing procedures that are not bundled into critical care shall not be included and counted toward critical care time (§30.6.12 E.3).	X			X						
5993.7	Contractor shall instruct physicians and qualified NPPs that Medicare does not separately pay for routine daily updates or reports to family members as part of critical care time (§30.6.12 E.4).	X			X						
5993.7.1	Contractor shall instruct physicians and qualified NPPs that family counseling and/or discussions shall meet the criteria outlined in §30.6.12 E. 4.	X			X						
5993.7.2	Contractor shall instruct physicians and qualified NPPs that time involved in activities (e.g., review of literature, teaching sessions with physician residents) that do not directly contribute to the treatment shall not be counted toward critical care time (§30.6.12 E.5).	X			X						
5993.8	Contractor shall instruct physicians and qualified NPPs that critical care services are time-based and provided on an hourly or fraction of an hour basis (§30.6.12 F).	X			X						
5993.8.1	Contractor shall instruct physicians and qualified NPPs that payment shall not be restricted to a fixed number of hours, fixed number of days, or a fixed number of physicians on a per patient basis when critical care services meet medical necessity (§30.6.12 F).	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5993.8.2	Contractor shall instruct physicians and qualified NPPs that time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments (§30.6.12 F).	X			X						
5993.8.3	Contractor shall instruct physicians and qualified NPPs that only one physician shall bill for critical care services during any one single period of time (§30.6.12 F).	X			X						
5993.8.4	Contractor shall instruct physicians and qualified NPPs that Medicare Part B paid under the physician fee schedule shall not pay for critical care services billed on a "per shift" or "per day" basis (§30.6.12 F).	X			X						
5993.8.5	Contractor shall instruct physicians and qualified NPPs that a physician assigned to a critical care unit shall not report critical care for patients based on a "per shift" basis (§30.6.12 F).	X			X						
5993.8.6	Contractor shall instruct physicians and qualified NPPs that CPT code 99291 is used to report the first 30 – 74 minutes of critical care on a given calendar date (30.6.12 F).	X			X						
5993.8.7	Contractor shall instruct physicians and qualified NPPs that CPT code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care (§30.6.12 F).	X			X						
5993.8.8	Contractor shall instruct physicians and qualified NPPs that provision of critical care services less than 30 minutes total duration on a given calendar date shall be reported using an appropriate E/M code such as subsequent hospital care code and not a critical care code (§30.6.12 F).	X			X						
5993.8.9	Contractor shall instruct physicians and qualified NPPs to refer to the table in Section 30.6.12 G for guidance or the table in AMA CPT under Critical Care Services in selecting appropriate codes to report.	X			X						
5993.9	Contractor shall instruct physicians and qualified NPPs that when critical care services are performed in the hospital emergency department (ED) they may report only critical care code 99291 and 99292 and not ED codes (§30.6.12 H).	X			X						
5993.10	Contractor shall instruct physicians and qualified NPPs that when critical care services are performed on the same date after an earlier service was performed in the office/outpatient or inpatient hospital and critical care was not required at that time, both the critical care and other E/M services by the same physician are payable (§30.6.12 H).	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5993.10.1	Contractor shall instruct physicians and qualified NPPs that hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient.	X			X						
5993.10.2	Contractors shall advise physicians and qualified NPPs to submit documentation to support situations identified in 5993.10 (§30.6.12 H).	X			X						
5993.11	Contractor shall instruct physicians and qualified NPPs that medically necessary critical care services provided on the same date to the same patient by physicians of different specialties from the same group practice or from different groups that are not duplicative services are payable (§30.6.12 I).	X			X						
5993.12	Contractor shall instruct physicians and qualified NPPs that medical record documentation of each physician (or qualified NPP) shall be used to support medically necessary concurrent critical care services provided and billed by more than one physician or qualified NPP (§30.6.12 I).	X			X						
5993.13	Contractor shall instruct physicians and qualified NPPs that the first hour of critical care identified by CPT code 99291 shall be met by a single physician or qualified NPP (§30.6.12 I).	X			X						
5993.14	Contractor shall instruct physicians and qualified NPPs that the first hour of critical care by the same physician or qualified NPP may be performed continuously or in aggregated time increments by the same physician or qualified NPP (§30.6.12 I).	X			X						
5993.15	Contractor shall instruct physicians and qualified NPPs that subsequent critical care visits on a given calendar date by that physician or qualified NPP are reported using CPT code 99292 as directed in BR 5993.8.7.	X			X						
5993.16	Contractor shall instruct physicians and qualified NPPs that physicians in the same group practice who have the same specialty shall not each report an initial critical care code 99291 on a given date (§30.6.12 I).	X			X						
5993.17	Contractor shall instruct physicians and qualified NPPs that physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the contractor who adjudicates the claims (§30.6.12 I).	X			X						
5993.18	Contractor shall instruct physicians and qualified NPPs that a physician or qualified NPP who is providing "staff coverage" or "follow-up" for a clinician (physician or	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	qualified NPP) in the same group who provided the first hour of critical care shall bill CPT code 99292 for critical care services and not CPT code 99291 (§30.6.12 I).										
5993.19	Contractor shall instruct physicians and qualified NPPs on the procedures that are bundled into critical care services and not separately payable as stated in §30.6.12 J and AMA CPT under Critical Care Services.	X			X						
5993.20	Contractor shall instruct physicians and qualified NPPs that other medically necessary procedures not referenced as bundled procedures in BR 5993.19 shall be separately reported (§30.6.12 J).	X			X						
5993.21	Contractor shall instruct physicians and qualified NPPs that critical care services shall not be paid on the same calendar date the physician also reports a procedure code with a global surgical period unless the critical care is identified with CPT modifier -25 to indicate the critical care is a significant and separately identifiable E/M service above and beyond the usual pre-and post operative care of the procedure performed (§30.6.12 K).	X			X						
5993.21.1	Contractor shall instruct physicians and qualified NPPs that BR 5993.21 applies to any procedure with a 0, 10 or 90 days global period including cardiopulmonary resuscitation, CPT code 92950 (§30.6.12 K).	X			X						
5993.22	Contractor shall instruct physicians and qualified NPPs that in postoperative critical care when all surgical care is transferred to another physician the appropriate modifiers shall be used (§30.6.12 K).	X			X						
5993.22.1	In a scenario referenced in BR 5995.22, the surgeon shall report CPT modifier -54 for surgical care only (§30.6.12 K).	X			X						
5993.22.2	In a scenario referenced in BR 5993.22, the physician who assumes the transfer, e.g., intensivist, shall report CPT modifier -55 for postoperative management only (§30.6.12 K).	X			X						
5993.23	Contractor shall instruct physicians and qualified NPPs that medical record documentation by the surgeon and other physician to whom care is transferred shall support the transfer and claims (§30.6.12 K).	X			X						
5993.24	Contractor shall instruct physicians and qualified NPPs that preoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the full attention of the physician and critical care is unrelated to the specific anatomic injury or general surgical procedure performed (§30.6.12 L).	X			X						
5993.24.1	Contractor shall instruct physicians and qualified NPPs	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	that a patient described in BR 5993.24 may meet the definition of being critically ill where there is a high probability of imminent or life threatening deterioration in the patient's condition (§30.6.12 L).										
5993.24.2	Contractor shall instruct physicians and qualified NPPs that for services referenced in BR 5993.24 to be paid modifier -25 must be appended to the critical care code(s) 99291 and 99292 on the same date of the procedure by the same physician (§30.6.12 L).	X			X						
5993.24.3	Contractor shall instruct physicians and qualified NPPs that in addition to BR 5993.24.2, documentation (an appropriate ICD-9-CM code) must identify that the critical care was unrelated to the anatomical injury or surgical procedure performed (§30.6.12 L).	X			X						
5993.25	Contractor shall instruct physicians and NPPs that postoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the full attention of the physician and critical care is unrelated to the specific anatomic injury or general surgical procedure performed (§30.6.12 L).	X			X						
5993.25.1	Contractor shall instruct physicians and qualified NPPs that a patient described in BR 5993.25 may meet the definition of being critically ill where there is a high probability of imminent or life threatening deterioration in the patient's condition (§30.6.12 L).	X			X						
5993.25.2	Contractor shall instruct physicians and qualified NPPs that for services identified in BR 5993.25 to be paid, modifier -24 (unrelated E/M service during a postoperative period) must be appended to the critical care code(s) 99291 and 99292 on the given date of the procedure by the same physician (§30.6.12 L).	X			X						
5993.25.3	Contractor shall instruct physicians and qualified NPPs that in addition to BR 5993.25.2 documentation (an appropriate ICD-9-CM code) must identify that the critical care was unrelated to the anatomical injury or surgical procedure performed (§30.6.12 L).	X			X						
5993.25.4	Contractor shall instruct physicians and qualified NPPs that Medicare allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns (§30.6.12 L).	X			X						
5993.26	Contractor shall instruct teaching physicians that he/she must be present for the entire period of time for which the critical care services are reported (§30.6.12 M).	X			X						
5993.26.1	Contractor shall instruct teaching physicians that time	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	spent teaching residents shall not be counted towards critical care time (§30.6.12 M).										
5993.26.2	Contractor shall instruct teaching physicians that time spent by residents, in the absence of the teaching physician shall not be reported as critical care services (§30.6.12 M).	X			X						
5993.26.3	Contractor shall instruct teaching physicians that a combination of documentation by the teaching physician and resident may support critical care services (§30.6.12 M).	X			X						
5993.26.4	Contractor shall instruct teaching physicians that he/she may refer to documentation obtained by the resident but the teaching physician shall document substantive information as stated in section §30.6.12 M.	X			X						
5993.26.5	Contractor shall instruct teaching physicians that medical review criteria are the same for all physicians (§30.6.12 M).	X			X						
5993.27	Contractor shall instruct physicians and qualified NPPs that ventilator codes (CPT 94002 – 94004, 94660 and 94662 are not separately payable when critical care services are reported for the same patient (§30.6.12 N).	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5993.28	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5993.10	Example: Physician provides a hospital care visit to his patient in the morning. The patient's condition deteriorates and patient is transferred to a critical care unit where critical care services are provided. Physician may report both the hospital care service and critical care services.
5993.10.1	This is longstanding payment policy established at the beginning of the physician fee schedule.
5993.16 and 5993.18	Contractor may choose to create a local edit, if able, to identify duplicate claims for multiple CPT 99291 codes submitted for the same patient, same date and same group/specialty in addition to educating the physician community.
5993.21 and 5993.21.1	Refer to the Internet Only Manual, Publication 100-04, Claims Processing Manual, Chapter 12, Section 40.2 (Billing Requirements for Global Surgery , including subsection 9 (critical care).

Section B: For all other recommendations and supporting information, use this space:

The American Medical Association Current Procedural Terminology (CPT) 2008, Critical Care Services, pp.19 - 20

V. CONTACTS

Pre-Implementation Contact(s): Kit Scally (Cathleen.Scally@cms.hhs.gov)

Post-Implementation Contact(s): Appropriate Regional Office staff

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* use the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

(Rev. 1548, Issued: 07-089-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

CRITICAL CARE SERVICES (CODES 99291-99292)

A. Use of Critical Care Codes

Pay for services reported with CPT codes 99291 and 99292 when all the criteria for critical care and critical care services are met. Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.

Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care.

Consult the American Medical Association (AMA) CPT Manual for the applicable codes and guidance for critical care services provided to neonates, infants and children.

B. Critical Care Services and Medical Necessity

Critical care services must be medically necessary and reasonable. Services provided that do not meet critical care services or services provided for a patient who is not critically ill or injured in accordance with the above definitions and criteria but who happens to be in a critical care, intensive care, or other specialized care unit should be reported using another appropriate E/M code (e.g., subsequent hospital care, CPT codes 99231 - 99233).

As described in Section A, critical care services encompass both treatment of "vital organ failure" and "prevention of further life threatening deterioration of the patient's

condition." Therefore, although critical care may be delivered in a moment of crisis or upon being called to the patient's bedside emergently, this is not a requirement for providing critical care service. The treatment and management of the patient's condition, while not necessarily emergent, shall be required, based on the threat of imminent deterioration (i.e., the patient shall be critically ill or injured at the time of the physician's visit).

Chronic Illness and Critical Care:

Examples of patients whose medical condition may not warrant critical care services:

1. *Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.*

2. *Management of dialysis or care related to dialysis for a patient receiving ESRD hemodialysis does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence (refer to Chapter 8, §160.4). When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed, it may be billed as critical care if critical care requirements are met. Modifier –25 should be appended to the critical care code when applicable in this situation.*

Examples of patients whose medical condition may warrant critical care services:

1. *An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.*

2. *A 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.*

3. *A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.*

4. *A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.*

Examples of patients who may not satisfy Medicare medical necessity criteria, or do not meet critical care criteria or who do not have a critical care illness or injury and therefore not eligible for critical care payment:

1. *Patients admitted to a critical care unit because no other hospital beds were available;*

2. *Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose); and*

3. *Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.*

Providing medical care to a critically ill patient should not be automatically deemed to be a critical care service for the sole reason that the patient is critically ill or injured. While more than one physician may provide critical care services to a patient during the critical care episode of an illness or injury each physician must be managing one or more critical illness(es) or injury(ies) in whole or in part.

***EXAMPLE**: A dermatologist evaluates and treats a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist. The dermatologist should not report a service for critical care.*

C. Critical Care Services and Full Attention of the Physician

The duration of critical care services to be reported is the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. That time must be spent at the immediate bedside or elsewhere on the floor or unit so long as the physician is immediately available to the patient.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor may be reported as critical care, even when it does not occur at the bedside, if this time represents the physician's full attention to the management of the critically ill/injured patient.

For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

D. Critical Care Services and Qualified Non-Physician Practitioners (NPP)

Critical care services may be provided by qualified NPPs and reported for payment under the NPP's National Provider Identifier (NPI) when the services meet the definition and requirements of critical care services in Sections A and B. The provision of critical care services must be within the scope of practice and licensure requirements for the State in which the qualified NPP practices and provides the service(s). Collaboration, physician supervision and billing requirements must also be met. A physician assistant shall meet the general physician supervision requirements.

E. Critical Care Services and Physician Time

Critical care is a time- based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided. More than one physician can provide critical care at another time and be paid if the service meets critical care, is medically necessary and is not duplicative care. Concurrent care by more than one physician (generally representing different physician specialties) is payable if these requirements are met (refer to the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, §30 for concurrent care policy discussion).

The CPT critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated. Reporting CPT code 99291 is a prerequisite to reporting CPT code 99292. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician (§30.6.5).

1. *<u>Off the Unit/Floor</u>*

   Time spent in activities (excluding those identified previously in Section C) that occur outside of the unit or off the floor (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in evaluation and management services.

2. *<u>Split/Shared Service</u>*

   A split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as a critical care service. Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified non-physician practitioner for the specified reportable period of time.

   Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-

physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.

When CPT code time requirements for both 99291 and 99292 and critical care criteria are met for a medically necessary visit by a qualified NPP the service shall be billed using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.

3. *Unbundled Procedures*

Time involved performing procedures that are not bundled into critical care (i.e., billed and paid separately) may not be included and counted toward critical care time. The physician's progress note(s) in the medical record should document that time involved in the performance of separately billable procedures was not counted toward critical care time.

4. *Family Counseling/Discussions*

Critical care CPT codes 99291 and 99292 include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service. However, time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT), may be counted toward critical care time when these specific criteria are met:

a) The patient is unable or incompetent to participate in giving a history and/or making treatment decisions, and

b) The discussion is necessary for determining treatment decisions.

For family discussions, the physician should document:

a. The patient is unable or incompetent to participate in giving history and/or making treatment decisions

b. The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family",

c. Medically necessary treatment decisions for which the discussion was needed, and

d. A summary in the medical record that supports the medical necessity of the discussion

All other family discussions, no matter how lengthy, may not be additionally counted towards critical care. Telephone calls to family members and or surrogate decision-makers may be counted

towards critical care time, but only if they meet the same criteria as described in the aforementioned paragraph.

5. *Inappropriate Use of Time for Payment of Critical Care Services.*

   Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted towards the critical care time, even when they are performed in the critical care unit at a patient's bedside (e.g., review of literature, and teaching sessions with physician residents whether conducted on hospital rounds or in other venues).

F. Hours and Days of Critical Care that May Be Billed

Critical care service is a time-based service provided on an hourly or fraction of an hour basis. Payment should not be restricted to a fixed number of hours, a fixed number of physicians, or a fixed number of days, on a per patient basis, for medically necessary critical care services. Time counted towards critical care services may be continuous or intermittent and aggregated in time increments (e.g., 50 minutes of continuous clock time or (5) 10 minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient.

For Medicare Part B physician services paid under the physician fee schedule, critical care is not a service that is paid on a "shift" basis or a "per day" basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include: claims from several physicians submitting multiple units of critical care for a single patient, and submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date. Physicians assigned to a critical care unit (e.g., hospitalist, intensivist, etc.) may not report critical care for patients based on a 'per shift" basis.

The CPT code 99291 is used to report the first 30 - 74 minutes of critical care on a given calendar date of service. It should only be used once per calendar date per patient by the same physician or physician group of the same specialty. CPT code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care (See table below). Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

Clinical Example of Correct Billing of Time:

A patient arrives in the emergency department in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and not also emergency department services. The cardiologist may report the 35 minutes of critical care services (also CPT code 99291) provided in the ED. Additional critical care services by the cardiologist in the CCU may be reported on the same calendar date using 99292 or another appropriate E/M code depending on the clock time involved.

G. Counting of Units of Critical Care Services

The CPT code 99291 (critical care, first hour) is used to report the services of a physician providing full attention to a critically ill or critically injured patient from 30-74 minutes on a given date. Only one unit of CPT code 99291 may be billed by a physician for a patient on a given date. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician and would not each report CPT 99291on the same date of service.

The following illustrates the correct reporting of critical care services:

Total Duration of Critical Care	***Codes***
Less than 30 minutes	*99232 or 99233 or other appropriate E/M code*
30 - 74 minutes	*99291 x 1*
75 - 104 minutes	*99291 x 1 and 99292 x 1*
105 - 134 minutes	*99291 x1 and 99292 x 2*
135 - 164 minutes	*99291 x 1 and 99292 x 3*
165 - 194 minutes	*99291 x 1 and 99292 x 4*
194 minutes or longer	*99291 – 99292 as appropriate (per the*

	above illustrations)

H. Critical Care Services and Other Evaluation and Management Services Provided on Same Day

When critical care services are required upon the patient's presentation to the hospital emergency department, only critical care codes 99291 - 99292 may be reported. An emergency department visit code may not also be reported.

When critical care services are provided on a date where an inpatient hospital or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient.

Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other evaluation and management services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

I. Critical Care Services Provided by Physicians in Group Practice(s)

Medically necessary critical care services provided on the same calendar date to the same patient by physicians representing different medical specialties that are not duplicative services are payable. The medical specialists may be from the same group practice or from different group practices.

Critically ill or critically injured patients may require the care of more than one physician medical specialty. Concurrent critical care services provided by each physician must be medically necessary and not provided during the same instance of time. Medical record documentation must support the medical necessity of critical care services provided by each physician (or qualified NPP). Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §40, and the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, §30.)

CPT Code 99291

The initial critical care time, billed as CPT code 99291, must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical exam performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.

CPT Code 99292

Subsequent critical care visits performed on the same calendar date are reported using CPT code 99292. The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.

Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §30.6.)

Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the contractor that adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative, the critical care services may be reported by each regardless of their group practice relationship.

Two or more physicians in the same group practice who have different specialties and who provide critical care to a critically ill or critically injured patient may not in all cases each report the initial critical care code (CPT 99291) on the same date. When the group physicians are providing care that is unique to his/her individual medical specialty and managing at least one of the patient's critical illness(es) or critical injury(ies) then the initial critical care service may be payable to each.

However, if a physician or qualified NPP within a group provides "staff coverage" or "follow-up" for each other after the first hour of critical care services was provided on the same calendar date by the previous group clinician (physician or qualified NPP), the subsequent visits by the "covering" physician or qualified NPP in the group shall be billed using CPT critical care add-on code 99292. The appropriate individual NPI number shall be reported on the claim. The services will be paid at the specific physician fee schedule rate for the individual clinician (physician or qualified NPP) billing the service.

Clinical Examples of Critical Care Services

1. *Drs. Smith and Jones, pulmonary specialists, share a group practice. On Tuesday Dr. Smith provides critical care services to Mrs. Benson who is comatose and has been in the intensive care unit for 4 days following a motor vehicle accident. She has multiple organ dysfunction including cerebral hematoma, flail chest and*

pulmonary contusion. Later on the same calendar date Dr. Jones covers for Dr. Smith and provides critical care services. Medically necessary critical care services provided at the different time periods may be reported by both Drs. Smith and Jones. Dr. Smith would report CPT code 99291 for the initial visit and Dr. Jones, as part of the same group practice would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.

2. *Mr. Marks, a 79 year old comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates Mr. Marks and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits Mr. Marks to the observation unit for monitoring, and diagnostic and laboratory tests. In observation Mr. Marks has a cardiac arrest. His primary care physician provides 50 minutes of critical care services. Mr. Marks' is admitted to the intensive care unit. On the same calendar day Mr. Marks' condition deteriorates and he requires intermittent critical care services. In this scenario the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.*

J. Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291 – 99292

The following services when performed on the day a physician bills for critical care are included in the critical care service and should not be reported separately:

- *The interpretation of cardiac output measurements (CPT 93561, 93562);*
- *Chest x-rays, professional component (CPT 71010, 71015, 71020);*
- *Blood draw for specimen (CPT 36415);*
- *Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data-CPT 99090);*
- *Gastric intubation (CPT 43752, 91105);*
- *Pulse oximetry (CPT 94760, 94761, 94762);*
- *Temporary transcutaneous pacing (CPT 92953);*
- *Ventilator management (CPT 94002 – 94004, 94660, 94662); and*
- *Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600).*

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

K. Global Surgery

Critical care services shall not be paid on the same calendar date the physician also reports a procedure code with a global surgical period unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (CPT code 93503) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, shall be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10 or 90 day global period including cardiopulmonary resuscitation (CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR shall be excluded from the determination of the time spent providing critical care. In this instance it must be the physician who performs the resuscitation who bills for this service. Members of a code team must not each bill Medicare Part B for this service.

When postoperative critical care services (for procedures with a global surgical period) are provided by a physician other than the surgeon, no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, CPT modifiers "-54" (surgical care only) and "-55"(postoperative management only) must be used by the surgeon and intensivist who are submitting claims. Medical record documentation by the surgeon and the physician who assumes a transfer (e.g., intensivist) is required to support claims for services when CPT modifiers -54 and -55 are used indicating the transfer of care from the surgeon to the intensivist. Critical care services must meet all the conditions previously described in this manual section.

L. Critical Care Services Provided During Preoperative Portion and Postoperative Portion of Global Period of Procedure with 90 Day Global Period in Trauma and Burn Cases

Preoperative

Preoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the full attention of the physician, and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients may meet the definition of being critically ill and criteria for conditions where

there is a high probability of imminent or life threatening deterioration in the patient's condition.

Preoperatively, in order for these services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed shall be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Postoperative

Postoperatively, in order for critical care services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.
Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

M. Teaching Physician Criteria

In order for the teaching physician to bill for critical care services the teaching physician must meet the requirements for critical care described in the preceding sections. For CPT codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See IOM, Pub 100-04, Chapter12, § 100.1.4)

1. Teaching
Time spent teaching may not be counted towards critical care time. Time spent by the resident, in the absence of the teaching physician, cannot be billed by the teaching physician as critical care or other time-based services. Only time spent by the resident and teaching physician together with the patient or the teaching physician alone with the patient can be counted toward critical care time.

2. Documentation

A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for

critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment. However, the teaching physician medical record documentation must provide substantive information including: (1) the time the teaching physician spent providing critical care, (2) that the patient was critically ill during the time the teaching physician saw the patient, (3) what made the patient critically ill, and (4) the nature of the treatment and management provided by the teaching physician. The medical review criteria are the same for the teaching physician as for all physicians. (See the Medicare Claims Processing, Pub. 100-04, Chapter 12, §100.1.1 for teaching physician documentation guidance.)

Unacceptable Example of Documentation:

> *"I came and saw (the patient) and agree with (the resident)".*

Acceptable Example of Documentation:

> *"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."*

N. Ventilator Management

Medicare recognizes the ventilator codes (CPT codes 94002 - 94004, 94660 and 94662) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an evaluation and management service (e.g., critical care services, CPT codes 99291 - 99292) on the same day for the patient even when the evaluation and management service is billed with CPT modifier -25.